Care Coordination for Elderly Virginians
Policies and Procedures Manual

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Introduction

The purpose of this manual is to provide the agencies participating in the Care Coordination for Elderly Virginians Program with the policies and procedures for complying with their contracts with the Virginia Department for the Aging. It also serves as a framework for the development of standardized policies and procedures as we move towards a comprehensive statewide care coordination system for long-term care services. Copies of this manual are available from the Virginia Department for the Aging.

Background

In 1990, the Joint Subcommittee on Health Care for All Virginians, that later evolved into the Joint Commission on Health Care, outlined the following problems in Virginia's current long-term care system.

- A lack of strong leadership at the state level to coordinate services among the state agencies;
- A fragmented service delivery system at the local level in most localities; and
- An inadequate supply of community alternatives to institutionalization.

In response to these identified problems related to Virginia's long-term care system, the Joint Commission on Health Care recommended the implementation of the Case Management, now named Care Coordination, for Elderly Virginians Pilot Project under the direction of the Virginia Long-Term Care Council. Beginning in 1991, this initiative funded three pilot projects located in Planning Districts 1,2,3 and 4 in Southwest Virginia; Fairfax County and the cities of Fairfax and Falls Church and; Planning Districts 17, 18, 20, 21, and 22 in Eastern Virginia. Local area agencies on aging initiated the projects in Southwest and Eastern Virginia. The Fairfax County Department of Social Services led the project in Northern Virginia. It was estimated that half of the Commonwealth's elderly population resided in these pilot areas. Funding sources for the program included the state general fund, federal Medicaid funds, the required state match for Medicaid eligible clients, and consumer fees.

The Case Management project was the critical component for the development and implementation of a statewide comprehensive care coordination system. The goals of the project included:

- Targeting limited resources to elderly at highest risk of institutionalization regardless of income;
- Coordinating the delivery of multiple services;
- Supporting family caregiving;

- Facilitating client access to services; and
- Providing cost-effective services.

To achieve these goals, one person or organization assumed the responsibility for locating, coordinating and monitoring services. Specific responsibilities included: case finding and screening; in-person assessment of client needs and resources; development of care plans to meet identified needs; implementation of care plans; monitoring services clients received for quality and appropriateness and, periodic reassessment of client needs. Case managers were trained in completing multidimensional assessments and met qualification standards including knowledge, skills and abilities in the area of human services.

In February 1991, the Virginia Long-Term Council issued a request for proposals to evaluate the Case Management for Elderly Virginians Pilot Project. The contract was awarded to the Virginia Polytechnic Institute and State University Center for Gerontology. The evaluation, which took place over two years, was published in five reports (dated from December 1991 to September 1993). The reports are available from the Virginia Department for the Aging. The evaluation concluded that the project:

- Targeted limited resources to the elderly at highest risk of institutionalization;
- Improved coordination of services in most cases;
- Facilitated client access to services;
- Provided an appropriate level of support for family caregiving;
- Offered strong evidence that care coordination can be cost-effective if there are careful restraints of the cost of both the care coordination and the client services package and;
- Supplied a framework for the development of the Uniform Assessment Instrument.

In 1993, House Joint Resolution 601, supported by the Joint Commission on Health Care and passed by the General Assembly, requested the Secretary of Health and Human Services to develop and implement a statewide comprehensive case management system for long-term care that:

- Is available to serve all elderly clients;
- Has authority to authorize eligibility for all publicly financed long-term services;
- Is supervised and managed at the state level but administered at the local level; and
- Is financed through a combination of funding sources including federal, state and local funds and consumers fees (based on ability to pay).

The resolution requested the Secretary of Health and Human Resources to require that all public health and human resource agencies use a uniform assessment instrument, common definitions and common criteria for all long-term care programs by July 1, 1994

and, develop and implement a statewide client level data base for all publicly funded long-term care services by July 1, 1995. After submitting these requests to the Secretary of Health and Human Services, the Virginia Long-Term Council was disbanded.

The success of the Pilot Project is evidenced by the expansion of the program. In 2002, eighteen area agencies on aging administer, under the auspices of the Virginia Department for the Aging, the Care Coordination for Elderly Virginians Program. (Appendix 1) The AIM system, as implemented by the Virginia Department for the Aging, records client information for the Care Coordination for Elderly Virginians Program.

Definition

Care Coordination is assistance, either in the form of accessing needed services, benefits, and/or resources or, arranging, in circumstances where the older person and/or their care givers are experiencing diminished functioning capacities, personal conditions or other characteristics, the needed services by providers.[1] Care Coordination is a distinct and comprehensive service. It entails investigating a person's needs and resources, linking the person to a full range of appropriate services, using all available funding sources and monitoring the care provided over an extended period of time.

Eligible Population

Care Coordination shall be targeted to those older persons, age 60 years and over, who are frail, or have disabilities, or who are at risk of institutional placement. Priority shall be given to older persons who are in the greatest economic or social need and/or residing in rural and geographically isolated areas with particular attention to low-income minority individuals.[2] Such persons shall also be unable to maintain independent living and self-sufficiency in their community due to the inability to define, locate, secure or retain the necessary resources and services of multiple providers on an on-going basis and shall be dependent in two (2) or more activities of daily living.

Unlike Medicaid or Title III elderly care coordination, the state-funded Care Coordination for Elderly Virginians Program is not an entitlement program. Care coordination shall be available to the extent that state appropriations allow.

The agency may decide to deny care coordination services if the agency determines the client can be better served/more efficiently served in an institutional setting.

Service Delivery Elements

Care Coordination providers must perform all of the following:

[1] NAPIS
[2] Older Americans Act of 1965 as amended, Section 306 (a)(4)(A)(i)

Outreach: Outreach is the proactive seeking of older persons who may be in need of care coordination. It involves defining and identifying a target population, and devising an outreach mechanism for educating this population about the program. Outreach makes the service known to other providers and helps assure proper referrals and coordination of care.

Intake/Screening: Intake/screening is an initial evaluation of a person's needs for care coordination and/or another service. The purpose is to obtain enough information to determine the person's likelihood of needing care coordination or another service and whether a full reassessment is needed. The information obtained includes the reason for the referral or for the individual seeking help, the informal and formal supports already available, and basic information such as age and income that relates to eligibility for services. Intake/Screening may be provided in the area agency on aging offices, at senior centers and other community facilities or in the older person's residence or by telephone.

Assessment: The assessment, using the full Uniform Assessment Instrument (UAI), identifies the person's care needs beyond the presenting problem in the areas of physical, cognitive, social and emotional functioning as well as financial and environmental needs. It also includes a detailed review of the person's current support from family, friends and formal service providers.

The assessment is conducted prior to provision of any further care coordination services. The assessment interview is conducted with the older person and, if applicable and with the person's permission, his or her caregiver(s). It is conducted in the person's residence. If the person is institutionalized or temporarily in another residence, a home visit is conducted after the person's return to the residence. No longer than fifteen (15) working days shall pass between the time a client is referred for care coordination services and a full Uniform Assessment Instrument is completed.

- A "Determine Your Nutritional Health" Nutritional Screening shall be completed on each client.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.

- The applicable sliding fee scale shall determine any fee for service charge to the client.

Care Planning: The care plan is the link from the assessment to the delivery of services. Working with the person and the caregivers, the care coordinator develops a plan to address the problems and strengths identified in the assessment; the establishment of desired client-specific goals; the development of a complete list of services to achieve these goals, the responsibilities of the care

coordinator, client, and informal and formal supports; and the payment sources for services. The client's agreement with the care plan must be documented. The care plan must be developed within fifteen (15) working days of the completion of the full Uniform Assessment Instrument. Written notification of acceptance or denial into care coordination shall be given to the client within five (5) working days of completion of the plan of care.

If a change is needed on the care plan prior to the six months reassessment, it can be facilitated with a phone call to the client. The change should be noted on the care plan and in the care coordination progress notes. The Care Coordinator should make two copies of the revised care plan, mailing one to the client and retaining the other in the client's file.

Arranging for Service Delivery: Service delivery is the process through which the care coordinator arranges and/or authorizes services to implement the care plan. This may involve arranging for services to be provided by outside agencies through collaboration, formal request, or the use of purchase-of-service agreements; coordinating help given by family, friends, and volunteers; and requesting services provided directly by the care coordination agency.

Monitoring: Monitoring is the maintenance of monthly contact (phone, e-mail, in person) with the person, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the individual's current needs. Monitoring includes the function of verifying whether a service has been delivered and altering the care plan as the individual's needs change. Contact must be made monthly with the client for purposes of monitoring the implementation of the care plan.

Reassessment: Reassessment is the formal review of the client's status to determine whether the person's situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the person's needs have changed, the care plan is adjusted. This review is done at least every six months or with any significant change in the person's condition or services. The reassessment interview is conducted with the person in their home and, if applicable and with the person's permission, his or her caregiver(s). Reassessments must be completed at least every six months.

- A "Determine Your Nutritional Health" Nutritional Screening shall be completed on each client.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.

Termination:
Care Coordination services can be terminated at the discretion of the service

provider. Written notification of termination of care coordination services shall be mailed to the client 10 business days in advance of the date the action is to become effective.

Care Coordinator Qualifications

A qualified care coordinator must possess a combination of relevant work experience in human services or health care and education that indicates that the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the care coordinator's job application form or supporting documentation, or observable in the job or promotion interview.

Staff Qualifications:

- Knowledge: Care coordinators should have a knowledge of aging and/or the impact of disabilities and illness on aging; conducting client assessments (including psychosocial, health and functional factors) and their uses in care planning; interviewing techniques; consumers' rights; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written, and interpersonal communication principles and techniques; general principles of file documentation, and service planning process and the major components of a service plan.

- Skills: Care coordinators should have skills in establishing and sustaining interpersonal relationships; problem-solving; including negotiating with consumers and service providers; identifying and documenting a consumer's needs for resources, services and assistance; identifying services within the established services system to meet the consumer's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the services of elderly person's and team-building.

- Ability: Care coordinators should have the ability to communicate with persons of different socio-economic and ethnic backgrounds; conduct an effective interview; arrange and negotiate service referrals; work independently, performing position duties under general supervision; work as a team member, maintaining effective inter- and intra-agency working relationships; and communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds, and interview.

Individuals meeting all the above qualifications shall be considered a qualified care coordinator; however, it is preferred that the care coordinator possess a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition, it is preferable that the care coordinator have two years of satisfactory experience in the human services field working with the aged or

disabled. It is required that the individual complete training on the UAI prior to performing care coordination. This training may be training by a state agency (eg.VISSTA) or an agency training conducted by a care coordination program manager or program related person.

Job Description: For each paid and volunteer position an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required.
- A current description of the minimum entry-level standards of performance for each job.

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client's rights; characteristics and resources of the community; and techniques for conducting the assessment, care planning, service arrangement, and monitoring.
- Each staff person must participate in a ten (10) hour in-service training per year. Content should be based on the Care Coordinator's need for professional growth and upgrading of skills.

Care Coordination Work Group

The initial function of the Care Coordination Work Group was to serve in an advisory capacity to Virginia's Long Term Care Council for the Case Management for Elderly Virginians Project. With the dissolution of the Long Term Care Council, the Work Group now guides the development of a statewide care coordination system for elderly Virginians in conjunction with the Virginia Department for the Aging. The membership of the work group includes the executive directors of the agencies having a Care Coordination for Elderly Virginians Program or their representatives, the Virginia Department for the Aging Care Coordination Project Director and other staff to the work group. The co-chair of the work group will be elected from the work group membership.

An agenda, that includes the following sections, will provide structure to the Care Coordination Work Group meetings: approval of the agenda, approval of the report of the previous meeting, public comment period, project manager's report, project site updates, old business and new business. The members will provide input to the agenda through the Care Coordination Project Manager. The group will meet as necessary to the conduct the business of the work group and to foster the development of a successful statewide Care Coordination for Elderly Virginians Program.

Some of the functions of the Care Coordination Work Group include:

- Identifying areas in which operating policies and procedures should be uniform across the state and those policies and procedures that should be left to local discretion;
- Providing input and comment to policies relating to care coordination as proposed by the Virginia Department for the Aging;
- Resolving issues relevant to managing the ongoing activities of the program;
- Sharing information with one another about each program's plans, practice models, local obstacles, and best clinical practices;
- Facilitating the evaluation of care coordination projects;
- Developing a work plan for implementing, when appropriate, the evaluator's recommendation;
- Providing strategies for improving efficiency within each project site; and
- Identifying state policies that present obstacles to successful care coordination.

Care Coordination Bill of Rights

Care coordination agencies shall make a bill of rights available to all clients at the time of assessment. This is a statement of the rights of the person receiving care coordination services and includes basic tenets that should be followed in providing the service. The bill of rights shall include, but is not limited to, the following items:

- The right to be treated with respect and dignity.
- The right to self-determination, including participation in developing one's own plan of care.
- The right to privacy and confidentiality.
- The right to a fair and comprehensive assessment of one's need for services, based on functional, psychosocial and cognitive abilities.
- The right to access needed health and social services that are available.
- The right to know the cost of service prior to receiving the service, including eligibility for third party reimbursement.
- The right to be notified in writing of any change in services (including the cost of services), termination of service or discharge.
- The right to refuse any portion of the care plan.
- The right to withdraw from the process at any time.
- The right to a grievance procedure and appeals process in the event that one believes his or her rights have been violated or he or she has been treated improperly.
- The right to be informed of rights and responsibilities and pertinent care coordination agency policies.
- The right to be referred elsewhere if not eligible for care coordination services.

Documentation Requirements

Files shall be maintained on all clients receiving care coordination services. Files include the AIM database as well as the individual client hard copy files. A system of file

keeping shall be maintained that includes, but is not limited to, a written policy on the protection of client files that defines procedures governing their use and removal; conditions for release of information contained in the files; a written policy providing for the retention and storage of files for at least five (5) years from the date of the last service to the client and for the retention and storage of such files in the event the program discontinues operation, and maintenance of files in a secure storage area.

AIM (Advanced Information Manager)

The AIM database captures data from the Uniform Assessment Instrument. The information is used to record, measure and assess the quality, necessity and the provision of long-term care services. All assessments and reassessments completed on all individuals that come in contact with care coordination programs shall be entered into the database in an accurate and timely manner.

Individual Client Files

All client files shall include, at a minimum, the following:

- Intake instrument(s)

- Virginia Uniform Assessment Instrument (UAI)

  The Virginia Uniform Assessment Instrument (UAI) is comprised of a short component and a full assessment. The short component of the UAI (pages 1-4) shall be used for a brief review of demographics, formal service use, financial resources, physical environment and functional status in order to determine the necessity of a full assessment. The full assessment (pages 1-12) shall be used for all clients referred for care coordination services. The full assessment shall be completed within 15 working days after receipt of the referral. Emergency cases shall be screened immediately. Applicable components of the UAI shall be entered into AIM within 10 working days of their completion.

  Local agencies may supplement the Virginia Uniform Assessment Instrument as needed. (A copy of the UAI is contained in Appendix.)

- UAI/Plan of Care

  A plan of care shall be developed for all individuals offered care coordination services and completed within 15 working days of completion of the Virginia Uniform Assessment Instrument. The client and/or their responsible party must sign all care plans. The form titled "UAI/Plan of Care" shall be used for this purpose. (This form and instructions for completing it properly are contained in Appendix.)

  For all care coordination clients, the original Plan of Care is retained in the client's file. For Medicaid clients, a copy of the plan of care is sent to the

Department of Medical Assistance Services (DMAS) analyst assigned to the case management agency for review and to initiate the billing process.

It is not necessary to complete a new plan of care after conducting a reassessment. Original care plans may be updated as client needs and resources change. Updates shall be initialed and dated by the case manager and signed by the client and/or their responsible party.

Reauthorization for continued Medicaid coverage of care coordination services is completed as required per each case. An updated care plan is required to indicate new or continued objectives that will be carried out for the upcoming six-month period. The plan of care must be sent to the agency's assigned DMAS analyst prior to the end of the current authorization period to avoid risk of non-payment for care coordination.

- Monthly Progress Logs

  Care coordinators shall maintain documentation of services arranged for elderly care coordination clients. A monthly progress log, narrative notes or other form of documentation can accomplish this. The documentation shall list the dates of all contacts between care coordination staff, direct service providers and other persons/agencies pertinent to the client's situation. Documentation shall cover services obtained for the client, how the client is responding, what unmet needs remain, and the progress that is being made toward securing still needed services. Documentation shall also identify any change in the client's social, environmental and medical circumstances. (Sample progress log page in Appendix.)

- Care Coordination Outcome Report

  An outcome report shall be completed for every discharged care coordination client. The form titled "Care Coordination Outcome Report" shall be used for this purpose. For Medicaid clients, a copy of the outcome report is to be mailed to the DMAS analyst assigned to the care coordination agency unless the client is terminated on the same date as the end date of the authorization period. (The Care Coordination Outcome Report and instructions for its completion are in Appendix)

- Consent to Exchange Information Form

  To protect client confidentiality, a "Consent to Exchange Information" form has been designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs. It also can be used to assist agencies to obtain information needed from other agencies to determine an individual's eligibility for services or benefits. There are several reasons for sharing information:

1. Ascertain that people are getting the help they need;
2. Maintain continuity of services;
3. Avoid duplication and achieve efficiency;
4. Ensure coordinated services; and
5. Enforce service requirements.

The client must sign the consent to exchange information form at the start of care coordination. The signed consent form is kept in the client's file. This consent can be effective until the case is closed.

To ensure compliance with the requirements of the Privacy Protection Act, each time information is disclosed to any of the listed agencies on the Consent to Exchange Information form, staff of the disclosing agency must enter identifying information in the client's file. (Copies of the Consent to Exchange form, the Disclosure log and instructions are in the Appendix.)

- Care Coordination Fee Form

  Fees

  The fee for state funded care coordination shall be no greater than $150 per month. (There is no cost sharing in Title III B or Medicaid Care Coordination). A client who is enrolled between the 1st and 15th of the month shall be charged 100% of the expected monthly fee. A client who is enrolled between the 16th and the end of the month shall be charged 50% of the expected monthly fee.

  Cost-Sharing/Sliding Fee Scale

  Non-Medicaid clients shall be asked to share in the cost of providing care coordination services and the cost of any gap-filling services purchased on the client's behalf. Cost sharing will be based on the ability to pay. The most current edition, revised every July 1, of the Health Department's Sliding Fee Scale entitled "Health Department Income Levels for Determining Eligibility for Medical Services". The charts are based on "Number in Family" and "Annual Gross Income." The UAI definition of family shall be used.

  Care coordination applicants will furnish gross income information at the time of the initial care coordination assessment and at each reassessment. If a care coordination client's gross income changes during the period of time the client is receiving care coordination, it is the client's responsibility to inform the care coordinator of these changes. Care coordinators must let all clients know of this responsibility. If the client's gross income changes, determination of client fees shall be done within 30 days.

In keeping with the Health Department's policies, it is the care coordination applicant's responsibility to furnish the care coordination agency with the correct financial data and to provide written verification of such data (i.e., proof of income) in order for the agency to appropriately establish income level and applicable charges.

The proof of income shall reflect current income that is expected to be available during the next 12 months period. For purposes of the Care Coordination for Elderly Virginians Program, documents that are most suitable for determining gross income include "most recent income tax return" and "social security and other benefits" statements as defined by the current Health Department Manual. It is not necessary to place copies of these documents in the client's file.

In some cases, agencies will not be able to verify income. When this occurs, the agency worker shall obtain a signed declaration of income from the client and shall document the reasons that the client income cannot be verified. (eg. Copy of social security check, pension check) This client documentation of income, including reasons the income cannot be verified, shall be placed in the client's file. (The Care Coordination Fee Form is in the Appendix.)

The care coordination team shall adjust gross income to take into account the expense of:

1. Medical/dental services that are prescribed by the client's physician and received by the patient but are not covered by Medicaid, Medicare or private insurance;
2. Modifications to the home for medical reasons;
3. Medical insurance premiums;
4. Cost of home/community based services identified as a need according to the UAI and not available without cost to the client.
   This adjusted gross income can be used in place of gross income to determine applicable charges.

Out of pocket costs to the client of the following home and community based services shall be used to adjust gross income when the service is essential to keeping the client in the home:

1. Adult day care;
2. Companion/chore/homemaker services;
3. Emergency alert systems;
4. Home delivered meals;
5. Personal care services;
6. Respite services;
7. Transportation to medical appointments and/or adult day care, and
8. Non-medical home repairs essential for the health and safety of the client.

Client Billing:

Clients shall be given a statement of the fees for which they are responsible (Form titled "Care Coordination Fee" that is included in the Appendix shall be used for this purpose.)

Consumer Contributions/Program Income
The Area Agency on Aging shall formally adopt written policies and procedures, approved by the governing board, regarding the collection, disposition, and accounting for program income.[3]

- Cost Sharing/Fee for Service – Title III Care Coordination: An Area Agency on Aging is not permitted to implement cost sharing/fee for service for recipients of this service.[4]
- Cost Sharing/Fee for Service – CCEVP: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[5]
- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[6]

Purchase of Gap-Filling Services Form

Gap-filling services provide a mechanism to fill critical gaps in services which are short term and essential, but unavailable through any other means. These services are necessary to maintain the care coordination client safely in the community and may be purchased on behalf of care coordination clients.

The purchase of gap-filling services is subject to the same client cost sharing as applies to care coordination services. Further, no expenditure for service acquisition shall replace existing funding through other service programs. The percentage of care coordination funds that can be used to purchase services is given in the contracts between the projects and the Virginia Department for the Aging.

Medicaid eligible and non-Medicaid eligible elderly care coordination clients may benefit from the purchases of services with state care coordination funds. If a Medicaid eligible client is receiving elderly care coordination through a Medicaid certified care coordination agency other than a CCEVP agency, the Medicaid care coordination may submit requests for the purchase of gap-filling services to the CCEVP team.

[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[4] Older Americans Act of 1965, as amended, Section 315(a)
[5] Ibid
[6] Older Americans Act of 1965, as amended, Section 315(b)

Appropriate Purchase of Goods/Services Include, but are not limited to:

1. Assistive transportation to medical appointments /services.
2. Nutritional supplements, ordered by a physician.
3. Incontinence supplies.
4. Durable medical equipment (not covered by insurance) ordered by a physician. Rentals should be encouraged when needed for limited use.
5. Prescription assistance.
6. An interim in-home service while Medicaid application is in process.
7. Adaptive equipment (ie. Microwaves, raised commode seats, special eating utensils) when documented that this equipment allows the client to maintain or increase functioning.
8. Minor home repairs (such as hand rails, steps) when documented that this repair is necessary in order for the client to remain safely at home.
9. Cleaning of the home or extermination of pests and rodents so that home services can be delivered.
10. Smoke detectors, and/or hearing aids (not covered by insurance) ordered by a physician.
11. Glasses, dentures, and/or hearing aids (not covered by insurance) ordered by a physician.
12. Utility assistance for the clients subject to disconnection when loss of service would affect the safety, health and well being of the client. This would also include heating assistance with oil, coal and wood.
13. Rent, groceries, blankets, clothes in order to provide time to receive assistance from other sources.
14. Purchase of services such a homemaker, personal care-type services, companion/chore and respite care
15. Purchase of services (listed above) to leverage additional service support for the client.

It is inappropriate to purchase services that are provided by the same agency providing care coordination, ie. homemaker, home delivered meals. Exceptions will be allowed for emergency situations and for agencies that document in the client's file that there are no other agencies providing the needed service in the area or that other agencies cannot serve the client. Documentation must include other funding sources explored and the reason why each source would not fund part or all of the service or equipment.

Gap-Filling Services Allocation

Purchases must be prioritized based on the necessity of the service in allowing the client to remain safely in the community setting. Gap-filling funds shall be made available to care coordination clients throughout the funding cycle. Each agency shall develop a cap on the maximum allowable expenditures per care coordination client. The agency shall retain documentation of how the cap was determined and any situations in which the cap is waived.

Care coordination and gap-filling funds **must not** be offered to individuals who have a one time need and who do not require coordination of multiple services. (eg. Individuals not receiving care coordination service) All gap-filling fund purchases shall be approved by one of the following: a committee, the care coordination case supervisor or the agency director. However, agencies may allow care coordinators the flexibility in approving the use of gap-filling funds for purchases. The agencies must develop written criteria under which care coordinators can authorize purchases. Such purchases must be monitored on a periodic basis by the care coordination supervisor.

Questions to ask before allocating funds for goods or services:

1. Has the client received gap filling funded goods or services in the past? If so, why does the client need them again? Is this the most cost effective approach for this client? Does the total service package cost less than institutional care?
2. Are services/goods available through any other funding sources?
3. Is it necessary to maintain or increase the person's level of independence?
4. Is it truly a one-time purchase or an interim measure? Is there a long-range plan for meeting the need? What are the long-term benefits of the purchase?
5. Are there any cost sharing options – family, other service groups, etc?
6. Does the service/equipment provided require assistance from others or training? If yes, is it available? Will the client use it?

Documentation of Gap-Filling Service Purchases

There must be documentation of each gap-filling service purchase that includes, at a minimum, the following:

- Name of client.
- Service/good received.
- Delivery date(s) of the service/good.
- Client benefits expected from purchasing the service/good.
- Total amount requested.
- Total cost of purchase.
- Client cost sharing amount.
- Organization (explanation required if this is the same organization which employs the case manager authorizing the service).
- Other organizations/funding sources explored.
- Purchase order number.
- Signature and title of who authorized, date signed.

Care coordination agencies may use the Purchase of Gap-filling Service Form found in the Appendix or develop an alternative which meets the above criteria. A copy of this form must be included in each client file if gap-filling funds are used for the client. It is acceptable to have documentation noted throughout the client file on progress notes, the care plan or other notes, but it must be

consolidated on one form. A copy of the form must also be in one central location in order to have documentation of all gap-filling service purchases made on behalf of all care coordination clients. It is not necessary to include a copy of the invoice in the client's file. The invoice may be in a central location and easily retrieved by the purchase order number on the client's documentation sheet.

Acceptance/Denial Notice

Care coordination agencies must notify clients in writing of acceptance into care coordination, of denial of care coordination, and of termination of care coordination.

Written notifications of denial of care coordination must me mailed within five (5) working days of the decision to deny services. Written notification of termination of care coordination services shall be mailed ten (10) working days in advance of the date the action is to become effective, the reason(s) for the decision and a number for the client to call to discuss the decision and/or gain information about other services available. Denial or termination notices must also include a statement about the client's right to appeal the decision. The following notice must be included in every decision letter (revision or denial) for Medicaid clients:

"You may request reconsideration of the decision by notifying, in writing, Adult Services Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. This written request for reconsideration must be filed with thirty (30) days of this notification. If you file a request for reconsideration before the effective date of this action, (date), services will continue during the reconsideration process."

Every decision to discharge clients from care coordination services must be reviewed prior to notifying the client, and copies of all written notices must be placed in the client's file.

Nutritional Screening

The "Determine Your Nutritional Health Nutrition Screening Checklist" must be completed on every care coordination client. (A copy of the Checklist is in the Appendix.) This form must be completed at each client reassessment. Nutritional screening information is entered into AIM.

Federal Poverty/VDA Sliding Fee Scale

Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.

Complaint and Appeals

Complaint and appeals procedures shall include at least the following elements:

1. The agency has the obligation to make information that explains the complaint and appeals procedure readily available.
2. The client has the right to be heard either in-person or through a representative.
3. The client has the right to be heard by an independent decision maker, that is, one who has no professional or personal affiliation with the agency.
4. The client has the right to a prompt and timely response/decision.
5. The client has the right to receive a response/decision in writing.
6. All complaints and appeals shall be documented.

Refer to the Department of Medical Assistance Services provider manual for complaint/appeal procedure for Medicaid-funded care coordination clients.

Adult Protective Services

As mandated reporters, all care coordination staff are required to report the suspected abuse, neglect or exploitation of adults and to cooperate with any adult protective services investigation.

Safety Procedures for Care Coordinators

All care coordination agencies must provide basic training and information regarding safety procedures for care coordinators on home visits. A record of such training will be kept by the agency.

Quality Assurance and Program Evaluation

The purpose of quality assurance and program evaluation is to find out how well a program is meeting its stated goals. This information can be used to improve practice; meet funding requirements; document need for future funding; and improve, coordinate, or expand services in a particular community. These processes are important to generating useful information and should be a part of all care coordination activities.

At a minimum, quality assurance and program evaluation must address the following:

- Target Population: Are the people receiving care coordination part of the intended target population?
- Response Time: How much time does it take to conduct the assessment and complete the care plan?
- Implementation: Is the care completed as written? Are the goals met? Are the client's preferences for care implemented?
- Adequacy of services: Do the care plan's services meet the client's needs?

- Cost effectiveness: Are the care plans providing adequate and appropriate services in a cost-effective manner?

Quality assurance and program evaluation should be an ongoing activity conducted at both the state and local level. State program monitors will use a utilization review form to determine that proper care coordination client files are being maintained by the care coordination agency.

Criminal Background Checks:

- VDA strongly recommends that the agency and its contractors to protect their vulnerable older clients by conducting criminal background checks for staff providing any service where they go into a client's home.

State Agency Responsibilities

State staff will carry out the following quality assurance and program evaluation activities through the use of onsite agency visits, utilization reviews of client records and satisfaction surveys and, analysis of data contained in the care coordination agency's Aging Monthly Report and AIM (Advanced Information Manager) Report:

- Ascertain compliance with the Care Coordination for Elderly Virginians Policies and Procedures Manual.
- Evaluate the administrative organization and practices of the program.
- Review documentation of staff competence.
- Verify in a random sample of client records:
    1. Compliance with Care Coordination for Elderly Virginians Policies and Procedures;
    2. Client eligibility;
    3. Timely delivery of services;
    4. Utilization and coordination of services in relation to the client, his/her family and community resources;
    5. Maintenance of appropriate level of care for the client and;
    6. Initiation of appropriate action when unavailable services are detected.

Onsite Agency Monitoring

Virginia Department for the Aging (VDA) staff will make periodic announced program and fiscal monitoring visits of each care coordination agency. Program monitoring can include a review of client files. Fiscal monitoring focuses on the care coordination agency's contract compliance. Program and financial monitoring instruments and a review of the monitoring activities are provided by VDA to the care coordination agencies prior to the monitoring visit. VDA staff will conduct an exit interview with the care coordination supervisor and other interested staff to present a general review of the findings. A written report of the monitoring visit will be provided to the care coordination agency by VDA within sixty (60) working days of the monitoring visit.

Client Satisfaction Surveys

Virginia Department for the Aging staff will periodically check client satisfaction surveys conducted by care coordination agencies. Surveys will be examined to determine the level of client and caregiver satisfaction with the care coordination agency's services.

Care Coordination Reporting Procedures

The Advanced Information Manager (AIM)

The AIM (Advanced Information Manager) system is used by the Virginia Department for the Aging (VDA) to monitor and maintain records on care coordination. Units of service must be reported in AIM for each client receiving the care coordination service. Service units can be reported on a daily basis, but not aggregated (summarized) more than beyond one calendar month. Units of service include:

- Hours (All hours relating to care coordination services including travel time for Care Coordination for Elderly Virginians Program clients – assessment time is included if this process leads to care coordination)
- Persons served (unduplicated)

AIM client data is transmitted to VDA by the last day of the following month.

VDA periodically compiles reports of AIM data to share with local area agency on aging supervisors. These reports can include (but are not limited to): number of care coordination assessments and clients; inconsistent or missing UAI information; number of deficiencies in Activities of Daily Living (ADLs) and, length of time between an assessment and reassessment.

Aging Monthly Report (AMR)

A report on the Care Coordination for Elderly Virginians Program is included in the Aging Monthly Report submitted by local area agencies on aging to VDA. The report includes the total number of Level B care coordination clients year-to-date and pertinent financial information on the agency's Care Coordination for Elderly Virginians Program. The Aging Monthly Report is transmitted to VDA by the twelfth (12^{th}) day of the following month. If the area agency on aging provides the CCEVP, this report must be updated and submitted even if no expenditures or units of service occurred.

Local Agency Quality Assurance

Care coordination agency quality assurance activities outlined in this policy are a recommended set of tasks. Local agency quality assurance activities should include those

discussed in the state quality assurance and program evaluation. These quality assurance activities include a focus on structure, process and outcomes.

Each local agency shall develop a written plan for ensuring that quality assurance activities are completed. Recommendations include, but are not limited to:

Structure

- Screen applicants for care coordinator positions to ensure competence and that they meet the knowledge, skills, and abilities outlined in the care coordinator qualifications.
- Perform periodic reviews of client files and the AIM database to ensure established care coordination documentation requirements are followed.
- The ratio of clients to Care Coordinator must be reviewed annually and is dependent on the following:
  Characteristics of the target populations served (e.g., very frail, disoriented, without family support);
  Complexity of the care plan;
  Geographical size of the area covered, taking transportation difficulties into account;
  Availability of community-based services; and the extent of responsibility and control over funds that is exercised by the Care Coordinator.
- Conduct at least an annual performance and evaluation field visit with care coordinators.

Process

- Ensure that clients are assessed and provided services in a timely manner.
- Review client eligibility.
- Maintain cost effective delivery of services.

Outcome

- Conduct client/caregiver satisfaction surveys.
- Ensure that care plan goals are appropriate and achieved.
- Monitor the intervention of staff on changing client status.

APPENDICES

Appendix A

1. Uniform Assessment Instrument
2. UAI/ Plan of Care and Instructions
3. Care Coordination Services Monthly Progress Log
4. Care Coordination Outcome Report
5. Health Department Income Levels
6. Care Coordination Fee Form
7. Purchase of Gap-Filling Services Form
8. Determine Your Nutritional Health
9. Virginia Service Quick Form
10. Disclosure Log

Appendix B

Consent to Exchange Information Form and Instructions
As revised in 1998 for Uniform Assessment Manual

Appendix C

Utilization Review Form

Appendix A

1. Uniform Assessment Instrument

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Date Screen: __ / __ / __
Assessment: __ / __ / __
Reassessment: __ / __ / __

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ Client SSN: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ City/County Code: _____

Directions to House: **Pets?**

Demographics

Birthdate: ____ / ____ / ____ **Age:** _____ **Sex:** ____ Male 0 ____ Female 1
(Month) (Day) (Year)

Marital Status: ____ Married 0 ____ Widowed 1 ____ Separated 2 ____ Divorced 3 ____ Single 4 ____ Unknown 9

Race:
____ White 0
____ Black/African American 1
____ American Indian 2
____ Oriental/Asian 3
____ Alaskan Native 4
____ Unknown 9 _____

Education:
____ Less than High School 0
____ Some High School 1
____ High School Graduate 2
____ Some College 3
____ College Graduate 4
____ Unknown 9

Communication of Needs:
____ Verbally, English 0
____ Verbally, Other Language 1
Specify: _____
____ Sign Language / Gestures / Device 2
____ Does Not Communicate 3
Hearing Impaired? ____

Ethnic Origin: _____ Specify: _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

CLIENT NAME:	Client SSN:

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	Provider/Frequency:
____	____	Adult Day Care	____
____	____	Adult Protective	____
____	____	Case Management	____
____	____	Chore/Companion/Homemaker	____
____	____	Congregate Meals/Senior Center	____
____	____	Financial Management/Counseling	____
____	____	Friendly Visitor/Telephone Reassurance	____
____	____	Habilitation/Supported Employee	____
____	____	Home Delivered Meals	____
____	____	Home Health/Rehabilitation	____
____	____	Home Repairs/Weatherization	____
____	____	Housing	____
____	____	Legal	____
____	____	Mental Health (Inpatient/Outpatient)	____
____	____	Mental Retardation	____
____	____	Personal Care	____
____	____	Respite	____
____	____	Substance Abuse	____
____	____	Transportation	____
____	____	Vocational Rehab/Job Counseling	____
____	____	Other: ____	____

Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

____	$20,000 or More	($1,667 or More) 0
____	$15,000 - 19,999	($1,250 - $1,666) 1
____	$11,000 - 14,999	($ 917 - $1,249) 2
____	$ 9,500 - 10,999	($ 792 - $ 916) 3
____	$ 7,000 - 9,499	($ 583 - $ 791) 4
____	$ 5,500 - 6,999	($ 458 - $ 582) 5
____	$ 5,499 or Less	($ 457 or Less) 6
____	Unknown 9	

Number in Family unit: ____

Optional: Total monthly family income:

Do you currently receive income from…?

No 0	Yes		*Optional: Amount*
____	____	Black Lung,	____
____	____	Pension,	____
____	____	Social Security,	____
____	____	SSI / SSDI,	____
____	____	VA Benefits,	____
____	____	Wages / Salary,	____
____	____	Other,	____

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		*Names*
____	____	Legal Guardian,	____
____	____	Power of Attorney,	____
____	____	Representative Payee,	____
____	____	Other,	____

Do you receive any benefits or entitlements?

No 0	Yes 1	
____	____	Auxiliary Grant
____	____	Food Stamps
____	____	Fuel Assistance
____	____	General Relief
____	____	State and Local Hospitalization
____	____	Subsidized Housing
____	____	Tax Relief

What types of health insurance do you have?

No 0	Yes 1		
____	____	Medicare, #	____
____	____	Medicaid, #	____
		Pending: ☐ No 0 ☐ Yes 1	
		QMB/SLMB: ☐ No 0 ☐ Yes 1	
____	____	All Other Public / Private:	____

CLIENT NAME:	Client SSN:

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
____ House: Own 0				
____ House: Rent 1				
____ House: Other 2				
____ Apartment 3				
____ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
____ Adult Care Residence 50			
____ Adult Foster 60			
____ Nursing Facility 70			
____ Mental Health/ Retardation Facility 80			
____ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
____	____	Barriers to Access
____	____	Electrical Hazards
____	____	Fire Hazards / No Smoke Alarm
____	____	Insufficient Heat / Air Conditioning
____	____	Insufficient Hot Water / Water
____	____	Lack of / Poor Toilet Facilities (Inside/Outside)
____	____	Lack of / Defective Stove, Refrigerator, Freezer
____	____	Lack of / Defective Washer / Dryer
____	____	Lack of / Poor Bathing Facilities
____	____	Structural Problems
____	____	Telephone Not Accessible
____	____	Unsafe Neighborhood
____	____	Unsafe / Poor Lighting
____	____	Unsanitary Conditions
____	____	Other: _____

Describe Problems:

CLIENT NAME:	Client SSN:

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating / Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

____ No, Continue with **Section** 3 0 ____ Yes, Service Referrals 1 ____ Yes, No Service Referrals 2

Screener: _____ **Agency:** _____

CLIENT NAME:	Client SSN:

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have, you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as . . . (Who has it…Where is it…)**?**

No 0 Yes 1 *Location*

_____ _____ Living Will, _____

_____ _____ Durable Power of Attorney for Health Care, _____

_____ _____ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)**?**

Current Diagnoses **Date of Onset**

_____

_____

_____

_____

_____

Enter Codes for 3 Major, Active Diagnoses: _____ None 00 _____ DX1 _____ DX2 _____ DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Total No. of Medications: _____ (If 0, skip to Sensory Function) **Total No. of Tranquilizer/Psychotropic Drugs:** _____

Do you have any problems with medicine(s)…?

No 0 Yes 1

_____ _____ Adverse reactions / allergies

_____ _____ Cost of medication

_____ _____ Getting to the pharmacy

_____ _____ Taking them as instructed / prescribed

_____ _____ Understanding directions / schedule

How do you take your medications?

_____ Without assistance 0

_____ Administered / monitored by lay person 1

_____ Administered / monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

Diagnoses:
Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
Circulation (04)
Heart Trouble (05)
High Blood Pressure (06)
Other Cardiovascular Problems (07)
Dementia
Alzheimer's (08)
Non-Alzheimer's (09)
Developmental Disabilities
Mental Retardation (10)
Related Conditions
Autism (11)
Cerebral Palsy (12)
Epilepsy (13)
Friedreich's Ataxia (14)
Multiple Sclerosis (15)
Muscular Dystrophy (16)
Spina Bifida (17)
Digestive/Liver/Gall Bladder (18)
Endocrine (Gland) Problems
Diabetes (19)
Other Endocrine Problems (20)
Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
Arthritis/Rheumatoid Arthritis (23)
Osteoporosis (24)
Other Muscular/Skeletal Problems (25)
Neurological Problems
Brain Trauma/Injury (26)
Spinal Cord Injury (27)
Stroke (28)
Other Neurological Problems (29)
Psychiatric Problems
Anxiety Disorder (30)
Bipolar (31)
Major Depression (32)
Personality Disorder (33)
Schizophrenia (34)
Other Psychiatric Problems (35)
Respiratory Problems
Black Lung (36)
COPD (37)
Pneumonia (38)
Other Respiratory Problems (39)
Urinary/Reproductive Problems
Renal Failure (40)
Other Urinary/Reproductive Problems (41)
All Other Problems (42)

CLIENT NAME:	Client SSN:

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

_____ Within normal limits or instability corrected 0
_____ Limited motion 1
_____ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
____ None 000	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: _____
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** _____ **No 0** _____ **Yes 1**
Describe: _____

Are you on any special diet(s) for medical reasons?

____ None 0
____ Low Fat / Cholesterol 1
____ No / Low Salt 2
____ No / Low Sugar 3
____ Combination / Other 4

Do you take dietary supplements?

____ None 0
____ Occasionally 1
____ Daily, Not Primary Source 2
____ Daily, Primary Source 3
____ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
____	____	Food Allergies
____	____	Inadequate Food / Fluid Intake
____	____	Nausea / Vomiting / Diarrhea
____	____	Problems Eating Certain Foods
____	____	Problems Following Special Diets
____	____	Problems Swallowing
____	____	Taste Problems
____	____	Tooth or Mouth Problems
____	____	Other: _____

CLIENT NAME:	Client SSN:

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as …?

No 0	Yes 1		*Frequency*
____	____	Occupational	____
____	____	Physical	____
____	____	Reality/Remotivation	____
____	____	Respiratory	____
____	____	Speech	____
____	____	Other	____

Do you have pressure ulcers?

		Location/Size
____	None 0	
____	Stage I 1	____
____	Stage II 2	____
____	Stage III 3	____
____	Stage IV 4	____

Special Medical Procedures: Do you receive any special nursing care, such as …?

No 0	Yes 1		*Site, Type, Frequency*
____	____	Bowel/Bladder Training	____
____	____	Dialysis	____
____	____	Dressing/Wound Care	____
____	____	Eyecare	____
____	____	Glucose/Blood Sugar	____
____	____	Infections/IV Therapy	____
____	____	Oxygen	____
____	____	Radiation/Chemotherapy	____
____	____	Restraints (Physical/Chemical)	____
____	____	ROM Exercise	____
____	____	Trach Care/Suctioning	____
____	____	Ventilator	____
____	____	Other:	____

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ____ No 0 ____ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: ____ Date: ____

Others: ____ Date: ____
(Signature/Title)

CLIENT NAME: **Client SSN:**

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).
Place: **Where are we now** *(state, country, town, street/route number, street name/box number)?*
Give the client 1 point for each correct response.
Time: **Would you tell me the date today** *(year, season, date, day, month)***?**

_____ Oriented 0
_____ Disoriented – Some spheres, some of the time 1
_____ Disoriented – Some spheres, all the time 2
_____ Disoriented – All spheres, some of the time 3
_____ Disoriented – All spheres, of the time 4
_____ Comatose 5

Spheres affected: _____

Recall/Memory/Judgment

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)**?**

Judgment: **If you needed help at night, what would you do?**

No 0	Yes 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Optional: **MMSE Score**

_____ (5)
_____ (5)
_____ (3)
_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

_____ Appropriate 0
_____ Wandering / Passive – Less than weekly 1
_____ Wandering / Passive – Weekly or more 2
_____ Abusive / Aggressive / Disruptive – Less than weekly 3
_____ Abusive / Aggressive / Disruptive – Weekly or more 4
_____ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
____	____	Change in work/employment	____	____	Financial problems	____	____	Victim of a crime
____	____	Death of someone close	____	____	Major illness - family/friend	____	____	Failing health
____	____	Family conflict	____	____	Recent move/relocation	____	____	Other: _____

CLIENT NAME:	Client SSN:

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living … or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite … that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

_____ _____ Solitary Activities, _____

_____ _____ With Friends / Family, _____

_____ _____ With Groups / Clubs, _____

_____ _____ Religious Activities, _____

How often do you talk with your children family or friends either during a visit or over the phone?

Children	Other Family	Friends / Neighbors
_____ No Children 0	_____ No Other Family 0	_____ No Friends/Neighbors 0
_____ Daily 1	_____ Daily 1	_____ Daily 1
_____ Weekly 2	_____ Weekly 2	_____ Weekly 2
_____ Monthly 3	_____ Monthly 3	_____ Monthly 3
_____ Less than Monthly 4	_____ Less than Monthly 4	_____ Less than Monthly 4
_____ Never 5	_____ Never 5	_____ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

_____ No 0 _____ Yes 1

CLIENT NAME:	Client SSN:

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

_____ No 0 _____ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	**Do (did) you ever use alcohol/other mood-altering substances with …**	**Do (did) you ever use alcohol/other mood-altering substances to help you …**
_____ No 0 _____ Yes 1 **Describe concerns:** _____	No 0 Yes 1 _____ _____ Prescription drugs? _____ _____ OTC medicine? _____ _____ Other substances? **Describe what and how often:**	No 0 Yes 1 _____ _____ Sleep? _____ _____ Relax? _____ _____ Get more energy? _____ _____ Relieve worries? _____ _____ Relieve physical pain? **Describe what and how often:**

Do (did) you ever smoke or use tobacco products?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

CLIENT NAME:	Client SSN:

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

_____ **No** 0 (Skip to Section on Preferences) _____ **Yes** 1

Where does the caregiver live?

_____ With client 0
_____ Separate residence, close proximity 1
_____ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

_____ Adequate to meet the client's needs? 0
_____ Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

_____ Not at all 0
_____ Somewhat 1
_____ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preference for receiving needed care: _____

Family/Representative's preference for client's care: _____

Physician's comments (if applicable)**:** _____

CLIENT NAME:	Client SSN:

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)
____	____	Finances
____	____	Home / Physical Environment
____	____	ADLS
____	____	IADLS

No 0	Yes 1	(Check All That Apply)
____	____	Assistive Devices / Medical Equipment
____	____	Medical Care / Health
____	____	Nutrition
____	____	Cognitive / Emotional
____	____	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

2. UAI Plan of Care and Instructions

UAI/Plan of Care

Client Name: _____ Social Security #_____ Medicaid # _____

Provider Name: _____ Provider ID #_____ Provider Phone #_____

Care Coordination Initiated: _____ (Date) Medicaid Eligibility Approved: _____ (Date – if after date initiated)

Medicaid Clients Only:

Initial Authorization: _____ (Must submit to DMAS prior to billing) Reauthorization: _____ (Must request 2 weeks prior to end date)

Goals: (Circle One or More)

1. To assist client to remain in his/her own home with supports as necessary.
2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.
3. To assist in arranging out-of-home placements as appropriate with either client/guardian consent or court orders.
4. Short-term assistance to access services.
5. Other Goals: _____

Unmet Need from UAI Summary	Measurable Objective To Meet Identified Need	Task(s) to Be Done to Meet Objective	Expected Time Frame	Date Resolved

Client Name: _____ Social Security #_____ Medicaid # _____

Unmet Need from UAI Summary	Measurable Objective To Meet Identified Need	Task(s) to Be Done to Meet Objective	Expected Time Frame	Date Resolved

Signatures: _____ _____
Recipient of Services/Date Care Coordinator/Date

Care Coordinator Comments:

Enrolled by DMAS: Services Effective____ End Date ____ DMAS Analyst ____ Date Enrolled _____

CARE COORDINATION PLAN OF CARE INSTRUCTIONS

Care plan means a standardized, written description of the need(s) which cannot be met by the adult care residence and the care coordinator's strategy for arranging services to that need(s). Care planning is the core of care coordination, and it is based on the information gathered during the assessment. The process of care planning includes (1) reviewing the assessment data, (2) using professional knowledge to determine available resources, (3) discussing options with the client, involved informal providers and the adult care residence staff, (4) writing the care plan, and (5) explaining and discussing it with the client and applicable caregivers. Specific components of the care plan developed for use with the Uniform Assessment Instrument are discussed below.

Identifying Information: Record the client's name, social security number, Medicaid number, the name of the Provider (the agency where the care coordinator developing the care plan works), the Provider ID number (Medicaid provider # for the care coordination agency) and the Provider phone number. In the next spaces, record the date care coordination started and the date Medicaid eligibility was approved. Only record the eligibility approval date if it is after the date care coordination started. Leave this space blank for non-Medicaid clients and /or clients who were Medicaid eligible before the initiation of care coordination.

Goals: These represent the overall goals of care coordination. Circle all that apply. There is also space to write in other goals specific to the client's situation. Goals represent the outcomes of care coordination and should guide the length of care coordination services. In other words, when the care coordinator and client feel thes goals have been met, consideration should be given to closing the client's case to ongoing ACR care coordination services.

Unmet Need from UAI Summary: List all of the unmet needs to be addressed in the care plan. These needs should correspond to those identified in the Summary Section of the Uniform Assessment Instrument. The reason for the unmet need should be clear from the UAI.

Measurable Objective to Meet Identified Need: A measurable objective is what the client and worker want to achieve for each identified need. These are more specific than the overall goals of care coordination services. They are written in terms of a client status that is observable or measurable so that the care coordinator and the client will be able to tell when the outcome has been attained. A common error is listing a service (e.g., home health aide) rather than a client status (e.g., improve functioning) as a measurable objective.

Answer the following questions to develop measurable objectives:

1. What is the problem that needs to be solved:

For example, you know the following information from administering the UAI to Mrs. Jones:
-Her lower dentures no longer fit;
-This limits her food intake;
-She has lost 10 pounds in 6 months, and
-She can't afford to have her dentures fixed.

The problem statement that summarizes this information is that Mrs. Jones is losing weight due to the lack of money to repair her dentures.

2. How will I know if the problem has been solved?
The answer to this question should be written in terms of a client status that is observable or measurable so that both parties will be able to tell when the outcome has been attained. Some other questions to ask yourself are: Will the client say or do something differently? Will I be able to observe the client doing something differently? Will I be able to observe the client doing something differently? Will the client's environment look different?

From the example above, the measurable objective is: Mrs. Jones will receive new denture and report eating all solid foods regularly. In writing the objective, focus on short-term changes you will be able to see and which will lead to long-term resolution of the problem. In this example, indicate that you will remove the apparent barrier to Mrs. Jones eating properly (obtain new dentures), and also say that you will observe her eating solid foods (which will then logically lead to improved nutrition).

Tasks to be Done to Meet the Objective: In this column, list the tasks to be done to meet each objective. These are the steps taken to solve the problem. Tasks will often involve obtaining a service for the client. For each service, list the provider and the frequency. Informal as well as formal providers should be included.

This may be the section you find easiest to complete. If so, you may want to fill out this section first, and then for each task think about the observable or tangible evidence that will be present to show that the task was accomplished. This would be recorded as the measurable objective (Column 2).

Expected Time Frame: This is the time frame for accomplishing the measurable objectives.

Date Resolved: Record the date the task was accomplished. If the ask was not accomplished, make a note of the reason.

Signatures: There is space for the client and/or their responsible party and the care coordinator to sign the care plan.

Care Coordinator Comments: The last section provides space for care coordinator comments.

3. Care Coordination Services Monthly Progress Log

Care Coordination Services Monthly Progress Log

Client Name: _____ **Medicaid ID#** _____ **Provider ID #** _____

Progress Log

Date	Action Taken	Results of Action Taken

Care Coordinator's Signature: _____ **Date:** _____

4. Care Coordination Outcome Report

CARE COORDINATION OUTCOME REPORT

CLIENT NAME: _____

Address: _____ Medicaid #_____
(Street)

_____ SSN: _____
(City) (State) (Zip)

PROVIDER AGENCY: _____ Agency Code: _____

Provider #: _____ Date Case Management Started:_____

Case Manager: _____ Date of Discharge: _____

INITIAL GOALS (Circle one primary goal)	**GOALS AT DISCHARGE**
1. To assist client to remain in his/her own home with supports, as necessary.	1. To assist client to remain in his/her own home with supports, as necessary.
2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.	2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.
3. To assist in arranging institutional Placements as appropriate with either Client/guardian consent or court orders.	3. To assist in arranging institutional placements as appropriate with either client/guardian consent or court orders.
4. Short-term assistance to access services.	4. Short-term assistance to access services.

REASON FOR DISCHARGE:

1. Client Institutionalized (NH or ACR)
2. Client No Longer Meets CM Criteria (<2ADL's/<2 unmet needs)
3. Care Plan Complete
4. Client/Family Withdrew From Service
5. Client Left The Area
6. Client Died
7. Agency Terminated Services
8. All Unmet Needs Addressed to Extent Possible

PLACE AT TIME OF DISCHARGE:

1. House
2. Apartment
3. Rented Room
4. Adult Care Residence
5. Adult Foster Home
6. Nursing Facility
7. Mental Health/Mental Retardation Facility
8. Homeless/Emergency Shelter

Describe Reasons for Discharge/Summary of Client's Situation:

Revised 1/25/01

WHAT IS A SUCCESSFUL OUTCOME

Goals

1. To assist client to remain in his/her own home with supports, as necessary.

2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.

3. To assist in arranging institutional placements as appropriate with either client/guardian consent or court orders.

4. Short-term assistance to access services.

PLACE AT TIME OF DISCHARGE:

1. House
2. Apartment
3. Rented Room
4. Adult Care Residence
5. Adult Foster Home
6. Nursing Facility
7. Mental Health/Mental Retardation Facility
8. Homeless/Emergency Shelter

HOW TO MEASURE A SUCCESSFUL OUTCOME:

If Goal	Then it will be a successful outcome if **Place at Time of Discharge** is:
1	1, 2, 3, 5,
2	1, 2, 3, 5,
3	4, 6, 7
4	1, 2, 3, 5,

INSTRUCTIONS – CARE COORDINATION OUTCOME REPORT

Outcome reports are completed when clients are discharged from case management services. All completed outcome reports go to data entry. For Medicaid clients, mail a copy of the outcome report to the Medicaid Utilization Review Analyst assigned to the case management agency. Follow the procedures below for completing the outcome report:

1. **Client Name:** Client's last name, first name and middle initial.

2. **Client Address:** Street, city, state and zip code of the place of residence of the client at the time of discharge.

3. **Medicaid #:** Client's Medicaid Number.

4. **SSN:** Client's 9-digit Social Security number as recorded on the Uniform Assessment Instrument. (UAI).

5. **Provider Agency Name:** Full name of the case management agency.

6. **Agency Code:** 3-digit code for the case management agency.

7. **Provider #:** Medicaid provider number for the case management agency.

8. **Date Case Management Started:** Date case management services were implemented.

9. **Case Manager Name:** Last name, first name and middle initial of the case manager.

10. **Date of Discharge:** Date case management services were terminated.

11. **Initial Goals:** Pick one primary goal. Pick the option that most accurately describes the goal of case management services when the service was implemented.

    1. To assist client to remain in his/her own home with supports, as necessary.

    2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.

    3. To assist in arranging institutional placements as appropriate with either client/guardian consent or court orders.

    4. Short-term assistance to access services.

12. **Goals at Discharge:** Circle the option that most accurately describes the goal of case management services at the time of discharge.

13. **Reason for Discharge:** Circle only one option. Pick the option that most accurately describes why the client was discharged from case management services. Use the space in the box to provide details.

    1. **Client Institutionalized (NH or ACR)** – The client is being placed in nursing home or adult Care Residence upon discharge from the program.

    2. **Client No Longer Meets Criteria (<2ADLs/<2unmet needs) –** The client's situation has improved and the client no longer is dependent in 2 ADLs and has less than 2 identified service needs for case management services.

    3. **Care Plan Completed** – All identified service needs on the Care Plan have been resolved.

    4. **Client/Family Withdrew From Service –** The client and/or a representative withdrew from case management services.

    5. **Client Left the Area –** Client moved out of the case management agency's service area.

    6. **Client Died –** Case management services were terminated because the client died.

    7. **Agency Terminated Services –** The case management agency terminated services for reasons such as difficulty with the client, lack of personnel to serve the client and/or other management **reasons.**

    8. **All Unmet Addressed to Extent Possible -** Case manager has exhausted all available resources to address client's needs.

14. **Place at Time of Discharge:** The place in which the client is residing at the time of discharge from case management services. Circle only one option.

5. Health Department Income Levels

CHART 1 - MAJORITY OF STATE

FEDERAL POVERTY / VDA SLIDING FEE SCALE

EFFECTIVE JULY 1, 2003

Client Name: _____ **SSN:** _____

Federal Poverty NUM. IN FAMILY		GROSS INCOME **Level A** **No Charge**	GROSS INCOME **Level B** **10% Charge**	GROSS INCOME **Level C** **25% Charge**	GROSS INCOME **Level D** **50% Charge**	GROSS INCOME **Level E** **75% Charge**	GROSS INCOME **Level F** **95% Charge**	GROSS INCOME **Level G** **100% Charge**
1	Annual	$0 - 8,980	8,981 - 9,878	9,879 - 11,970	11,971 - 14,961	14,962 - 17,960	17,961 - 22,450	22,451 and above
	Monthly	$0 - 748	749 - 823	824 - 998	999 - 1,247	1,248 - 1,497	1,498 - 1,871	1,872 and above
2	Annual	$0 - 12,120	12,121 - 13,332	13,333 - 16,156	16,157 - 20,192	20,193 - 24,240	24,241 - 30,300	30,301 and above
	Monthly	$0 - 1,010	1,011 - 1,111	1,112 - 1,346	1,347 - 1,683	1,684 - 2,020	2,021 - 2,525	2,526 and above
3	Annual	$0 - 15,260	15,261 - 16,786	16,787 - 20,342	20,343 - 25,423	25,424 - 30,520	30,521 - 38,150	38,151 and above
	Monthly	$0 - 1,272	1,273 - 1,399	1,400 - 1,695	1,696 - 2,119	2,120 - 2,543	2,544 - 3,179	3,180 and above
4	Annual	$0 - 18,400	18,401 - 20,240	20,241 - 24,527	24,528 - 30,654	30,655 - 36,800	36,801 - 46,000	46,001 and above
	Monthly	$0 - 1,533	1,534 - 1,687	1,688 - 2,044	2,045 - 2,555	2,556 - 3,067	3,068 - 3,833	3,834 and above
5	Annual	$0 - 21,540	21,541 - 23,694	23,695 - 28,713	28,714 - 35,886	35,887 - 43,080	43,081 - 53,850	53,851 and above
	Monthly	$0 - 1,795	1,796 - 1,975	1,976 - 2,393	2,394 - 2,990	2,991 - 3,590	3,591 - 4,488	4,489 and above
6	Annual	$0 - 24,680	24,681 - 27,148	27,149 - 32,898	32,899 - 41,117	41,118 - 49,360	49,361 - 61,700	61,701 and above
	Monthly	$0 - 2,057	2,058 - 2,262	2,263 - 2,742	2,743 - 3,426	3,427 - 4,113	4,114 - 5,142	5,143 and above
7	Annual	$0 - 27,820	27,821 - 30,602	30,603 - 37,084	37,085 - 46,348	46,349 - 55,640	55,641 - 69,550	69,551 and above
	Monthly	$0 - 2,318	2,319 - 2,550	2,551 - 3,090	3,091 - 3,862	3,863 - 4,637	4,638 - 5,796	5,797 and above
8	Annual	$0 - 30,960	30,961 - 34,056	34,057 - 41,270	41,271 - 51,579	51,580 - 61,920	61,921 - 77,400	77,401 and above
	Monthly	$0 - 2,580	2,581 - 2,838	2,839 - 3,439	3,440 - 4,298	4,299 - 5,160	5,161 - 6,450	6,451 and above
Each Added Person	Annual	$0 - 3,140	3,141 - 3,454	3,455 - 4,186	4,187 - 5,231	5,232 - 6,280	6,281 - 7,850	7,851 and above
	Monthly	$0 - 262	263 - 288	289 - 349	350 - 436	437 - 523	524 - 654	655 and above

Based on the poverty guidelines published in the February 7, 2003 edition of the Federal Register, pages 6456-6458.

Based on the Department of Health's "Regulations Governing Eligibility Standards And Charges For Health Care Services To Individuals", 12VAC5-200.

CHART 2 - NORTHERN VIRGINIA
FEDERAL POVERTY / VDA SLIDING FEE SCALE
EFFECTIVE JULY 1, 2003

Client Name: _____ **SSN:** _____

Federal Poverty GROSS INCOME	NUM. IN FAMILY		GROSS INCOME **Level A** No Charge	GROSS INCOME **Level B** 10% Charge	GROSS INCOME **Level C** 25% Charge	GROSS INCOME **Level D** 50% Charge	GROSS INCOME **Level E** 75% Charge	GROSS INCOME **Level F** 95% Charge	GROSS INCOME **Level G** 100% Charge
$0 - 8,980	**1**	Annual	$0- 9,878	9,879 - 11,970	11,971 - 14,961	14,962 - 17,960	17,961 - 20,950	20,951 - 25,440	25,441 and above
$0 - 748		Monthly	$0 - 823	824 - 998	999 - 1,247	1,248 - 1,497	1,498 - 1,746	1,747 - 2,120	2,121 and above
$0 - 12,120	**2**	Annual	$0- 13,332	13,333 - 16,156	16,157 - 20,192	20,193 - 24,240	24,241 - 28,276	28,277 - 34,336	34,337 and above
$0 - 1,010		Monthly	$0 - 1,111	1,112 - 1,346	1,347 - 1,683	1,684 - 2,020	2,021 - 2,356	2,357 - 2,861	2,862 and above
$0 - 15,260	**3**	Annual	$0- 16,786	16,787 - 20,342	20,343 - 25,423	25,424 - 30,520	30,521 - 35,602	35,603 - 43,232	43,233 and above
$0 - 1,272		Monthly	$0 - 1,399	1,400 - 1,695	1,696 - 2,119	2,120 - 2,543	2,544 - 2,967	2,968 - 3,603	3,604 and above
$0 - 18,400	**4**	Annual	$0- 20,240	20,241 - 24,527	24,528 - 30,654	30,655 - 36,800	36,801 - 42,927	42,928 - 52,127	52,128 and above
$0 - 1,533		Monthly	$0 - 1,687	1,688 - 2,044	2,045 - 2,555	2,556 - 3,067	3,068 - 3,577	3,578 - 4,344	4,345 and above
$0 - 21,540	**5**	Annual	$0- 23,694	23,695 - 28,713	28,714 - 35,886	35,887 - 43,080	43,081 - 50,253	50,254 - 61,023	61,024 and above
$0 - 1,795		Monthly	$0 - 1,975	1,976 - 2,393	2,394 - 2,990	2,992 - 3,590	3,591 - 4,188	4,189 - 5,085	5,086 and above
$0 - 24,680	**6**	Annual	$0- 27,148	27,149 - 32,898	32,899 - 41,117	41,118 - 49,360	49,361 - 57,578	57,579 - 69,918	69,919 and above
$0 - 2,057		Monthly	$0 - 2,262	2,263 - 2,742	2,743 - 3,426	3,427 - 4,113	4,114 - 4,798	4,799 - 5,827	5,828 and above
$0 - 27,820	**7**	Annual	$0- 30,602	30,603 - 37,084	37,085 - 46,348	46,349 - 55,640	55,641 - 64,904	64,905 - 78,814	78,815 and above
$0 - 2,318		Monthly	$0 - 2,550	2,551 - 3,090	3,091 - 3,862	3,863 - 4,637	4,638 - 5,409	5,410 - 6,568	6,569 and above
$0 - 30,960	**8**	Annual	$0- 34,056	34,057 - 41,270	41,271 - 51,579	51,580 - 61,920	61,921 - 72,230	72,231 - 87,710	87,711 and above
$0 - 2,580		Monthly	$0 - 2,838	2,839 - 3,439	3,440 - 4,298	4,299 - 5,160	5,161 - 6,019	6,020 - 7,309	7,310 and above
$0 - 3,140	Each	Annual	$0 - 3,454	3,455 - 4,186	4,187 - 5,231	5,232 - 6,280	6,281 - 7,326	7,327 - 8,896	8,897 and above
$0 - 262	Added Person	Monthly	$0 - 288	289 - 349	350 - 436	437 - 523	524 - 610	612 - 741	742 and above

Based on the poverty guidelines published in the February 7, 2003 edition of the Federal Register, pages 6456-6458.
Based on the Department of Health's "Regulations Governing Eligibility Standards And Charges For Health Care Services To Individuals", 12VAC5-200.

6. Care Coordination Fee Form

Care Coordination Fees

Care Coordination for Elderly Virginians Program

(Cost Sharing is not Permitted for Title III Care Coordination)

_____ gross income is _____ per year.
(Client's Name)

Income was verified with appropriate documentation: _____Yes _____ No

If no, explain,

_____
_____
_____
_____
_____

Income was adjusted by the following amount: _____

_____ adjusted income is _____ per year.
(Client's Name)

The percent of client's cost-sharing is: _____

The monthly fee is: _____ for care coordination services.

The monthly fee(s) for other services are specified below:

(Fee)	(Service)
(Fee)	(Service)
(Fee)	(Service)

I certify that the income of all persons in my family is not more than the amount shown on this form and that the other information I have given on this form is correct to the best of my knowledge and belief. I understand that failure to pay my agreed upon fee(s) may result in termination of services.

(Signature) (Date)

Net Income Worksheet

Case Manager:

Monthly Income for Month of:	Total Amount	Date Verified	Initial
Social Security			
Pension			
SSI/SDDI			
Wages, Salary			
Black Lung			
VA Benefits			
Public Assistance			
Rental Income			
Dividends, Annuities			
Contributions from Others			
Other:			
Total Gross Income			
Monthly Expenses			
Medical Expenses			
Durable or consumable medical goods			
Home modifications for health/safety			
Medical insurance premiums			
Home/community-based costs identified by UAI that client pays			
ADC			
Companion/Chore/Homemaker costs			
Personal Care			
Emergency Alert System			
HDM			
Transportation for urgent needs			
Dental Expenses			
Total Expenses			
TOTAL NET INCOME			

7. Purchase of Gap-Filling Services Form

Purchase of Gap-Filling Service Form
(Care Coordination for Elderly Virginians Program)

Client Name: _____

Service/good received: _____

_____

Delivery Dates(s) of the service/good: _____

Client benefits expected as a result of the service or equipment: _____

_____

_____

_____

_____

Organization providing service/good (explanation required if this is the same organization which employs the care coordinator authorizing the service): _____

_____

_____

_____

_____

Other organizations/funding sources explored: _____

_____

_____

_____

_____

TOTAL COST OF PURCHASE: $ _____

TOTAL AMOUNT REQUESTED: $ _____

CLIENT COST SHARING AMOUNT: $ _____

PURCHASE ORDER NUMBER: _____

REQUIRED SIGNATURE: _____

TITLE: _____ DATE: _____

8. Determine Your Nutritional Health

The Warning Signs of poor nutritional health are often overlooked. Use this Checklist to find out if you or someone you know is at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's –

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this Checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn the page to learn more about the Warnings Signs of poor nutritional health.

These materials are developed and distributed by the Nutrition Screening Initiative, a project of:

AMERICAN ACADEMY OF FAMILY PHYSICIANS
THE AMERICAN DIETETIC ASSOCIATION
THE NATIONAL COUNCIL ON THE AGING, INC.

The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well, or cause mouth sores, make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or choosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals, when taken in large doses, act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/GAIN

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

9. Virginia Service Quick Form

VIRGINIA SERVICE – QUICK FORM

Today's Date _____/_____/_____

Updated _____/_____/_____

Name & Demographic Information

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street)

_____
(City) (State) (Zip)

Phone: (____)_____ County/City of Residence: _____

Social Security Number: _____ Is There a Caregiver? Yes ____ No ____

Birthdate: _____/_____/_____ ____ Male ____ Female
(Month) (Day) (Year)

Race:

____ White ____ Oriental /Asian ____ Unknown

____ Black / African American ____ Alaskan Native

____ American Indian ____ Hispanic Origin

Physical Environment

_____ No one else lives in my home

_____ Yes I live with someone

Financial Resources

Number of members in immediate family: _____

Total monthly income of immediate family: $ _____

In Federal Poverty? Yes ____ No ____

Sliding Fee Scale Level? A____ B____ C____ D____ E____ F____ G____
(If applicable)

For Office Use Only

Services Requested:

_____

_____

Services Provided:

_____

_____

Agency / Provider: _____

NOTE: At a minimum, this form must be updated annually in order for a client to continue service.

10. Disclosure Log

DISCLOSURE LOG: CONSENT TO EXCHANGE INFORMATION

_____

(NAME OF AGENCY AND STAFF CONTACT PERSON)

_____ _____

(FULL PRINTED NAME OF CLIENT) *(CASE NUMBER)*

_____ _____ _____

(CLIENT'S ADDRESS) *(CLIENT'S BIRTH DATE)* *(CLIENT'S SSN - OPTIONAL)*

Log of Disclosure of Information:

Receiving Agency	Name, Title, Telephone Number of Individual Receiving Information	Type and Source of Information Disclosed	Reason or Purpose of Disclosure	Date Disclosed

Instructions for Preparing the Disclosure Log

PURPOSE - To ensure compliance with the requirements of the Virginia Privacy Protection Act. Each time information is disclosed by any of the lis ted agencies, staff of the disclosing agency must enter the following information in the client's record:

1. Name of the agency and the name, title, and telephone number of the individual receiving the information.
2. Type and source of the information disclosed.
3. Reason or purpose for the disclosure.
4. Date that the information was disclosed.

This requirement can be met either by using the disclosure log or by following the agency's current procedures to meet disclosure requirements.

CLIENT NAME - Enter the name, address, birthdate, and social security number (SSN) (optional) of the client about whom the information is disclosed.

LOG INFORMATION - Enter the information required in the appropriate box(es).

Appendix B

APPENDIX B: CONSENT TO EXCHANGE INFORMATION

Introduction

Specified information can be shared among ALL of the agencies listed below without having to obtain any additional signed consent from the client. The *Consent to Exchange Information* form was developed for use by the following agencies:

- Local departments of social services
- Area agencies on aging
- Health department clinics and programs
- Community services boards
- Department of Correctional Education
- Department of Youth and Family Services
- Service delivery areas for the Job Training Partnership Act
- Local departments of Rehabilitative Services
- Local school systems
- Regional offices, Department of Corrections
- Regional outreach offices, Department for the Deaf and Hard of Hearing
- Regional Offices, Department for the Visually Handicapped
- Virginia Employment Commission Offices

The "referring agency" is defined as the agency that initiates the completion of the *Consent to Exchange Information* form with the individual. The referring agency may use the form to request or to transmit information to other agencies. Agencies may be considered either a "referring" or an "other" agency, depending upon which agency is contacted first by the client. If all parties agree, additional public and private agencies, facilities, and organizations may be included.

Agencies are assured that, when properly executed, this is a legally valid form that meets not only their own agency's state and federal requirements, but also those of the other participating agencies. The *Consent to Exchange Information* form has been reviewed by the Office of the Attorney General to assure compliance with federal and state confidentiality requirements. Agencies may choose to use a different uniform release form that addresses their individual needs if it meets the state and federal confidentiality and release of information statutory and regulatory requirements of ALL involved agencies.

Alcohol and Drug Abuse Confidentiality Requirements

To ensure compliance with federal alcohol and drug abuse confidentiality requirements, this form excludes the general sharing of information about clients in drug and alcohol programs. A separate release of information form specifically for alcohol and drug abuse records should be used each time information is shared between agencies (see attached form).

Purpose of the Consent to Exchange Information Form

The *Consent to Exchange Information* form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs and should be used along with the referring agency's specific procedures for obtaining a valid release to exchange information. It also can be used to assist agencies obtain information needed from other agencies to determine an individual's eligibility for services or benefits. The completed form should reflect that the client (or his or her representative) controlled the choices and understood the process. When using this form, always keep in mind the importance of client wishes, client choices, and client comprehension of the process.

Agency staff and the consenting person will first determine whether the client might be eligible for services or benefits provided by other agencies. This determination should be based upon the needs, interests, and circumstances of the client as well as staff's knowledge of other agencies' services or benefits and eligibility requirements.

Referring agency staff must explain the following to the client:

- Potential services and benefits that might be available from other agencies.
- What information these agencies might need and for what purpose(s).
- The purpose of the form.
- The consequences of signing or not signing this release.
- Key provisions and protections (e.g., revocation, access to agencies' written record).

Staff should make every attempt to ensure that the consenting person understands the provisions of the form and should make appropriate efforts to accommodate the special needs of the consenting person. If the consenting person is unable to read or is blind or visually impaired, staff should read the form to him or her. Interpreters should be made available for people who do not speak English and for those who are deaf or hearing impaired. If the consenting person does not appear to comprehend the meaning of the form, it should be explained. If staff have ANY doubts that the consenting person is not comprehending the purpose and provisions of the form, they should ask the consenting person questions about the form (what the form allows the agency to do, etc.).

Based upon these answers, if staff determine that the consenting person is NOT comprehending the purpose and provisions of the form, staff should follow their agency's procedures for assuring that the form is signed by a legally authorized consenting person who fully comprehends the purpose and provisions of the form. The signature of a consenting person who does NOT comprehend what he or she is signing is not valid.

If the consenting person agrees, the form should be completed. This should be done by the consenting person, wherever possible. The consenting person must sign the form and insert the date in the indicated place. Staff explaining the form to the consenting person must sign the form

in the indicated place. For those agencies with procedures requiring a witness (e.g., for a person who cannot write), space is provided for a witness to sign the form. The witness must observe the consenting person signing or placing a mark on the form and then must sign as indicated. The referring agency must give a copy of the completed form to the consenting person.

Sharing Information with Other Agencies

It is important for the referring agency to notify the other listed agencies that they are parties to this agreement to exchange information. This notification can be by telephone or though written correspondence. This notification must be entered into the client's record. If the referring agency wants to receive information from other agencies, it must provide a copy of the signed consent form with its initial request for information form each listed agency.

Virginia Privacy Protection Act Requirements

To ensure compliance with the Virginia Privacy Protection Act, each time information is disclosed by any of the listed agencies, staff of the disclosing agency must enter the following information into the client's record:

- Name of the agency and the name, title, telephone number of the individual receiving the information.
- Type and source of the information disclosed.
- Reason or purpose for the disclosure.
- Date the information was disclosed.

This requirement can be met by using a disclosure log (sample attached) or through the agency's own record keeping policies and procedures.

NOTE: The consenting person has the right to review the records of disclosure of the referring and other agencies upon request during the agencies' normal business hours.

Agency Record Keeping Policies and Procedures

Referring Agency: The original signed copy of the *Consent to Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Other Agencies: A copy of the *Consent to Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Renewing or Amending the Consent Form

The referring agency can renew or amend (e.g., by adding additional agencies) the original signed copy of the *Consent to Exchange Information* form by having the consenting person sign and insert the date beside the amendment on the original form. The referring agency must

give a copy of the amended form to the consenting person and forward a copy of the amended form to each of the listed agencies.

Revocation of Consent

Consent to exchange information will expire on the date or condition agreed to by the consenting person. However, anytime prior to the expiration, the consenting person may choose to revoke or cancel this consent either with all or with selected agencies.

The consenting person may revoke his or her consent by informing any of the involved agencies in writing, by telephone, or in person. This notification must be noted on the back of the *Consent to Exchange Information* form and signed and dated by the agency staff person receiving the request to revoke the consent.

If the consenting person exercises the option of revoking his or her consent (in entirety or with selected agencies) to share information under the agreement, the agency receiving this notice shall inform all other listed agencies that are authorized to exchange information under the agreement of the revocation of the consent.

Clients Who Refuse to Sign the Consent Form

It is absolutely essential that the client understand and appreciate what will happen as a result of signing this form. The client also needs to understand that their is no requirement to sign this form, but that not signing the form will result in specific consequences. If the form is not signed, the client must deal with each agency individually to obtain needed information, and/or the agency may not be able to provide services. If the form is signed, the process for applying for and receiving services may be easier for both the client and the involved agencies.

When Not to Use This Form

The *Consent to Exchange Information* form should not be used with:

- Individuals who do not comprehend the purpose and substance of the consent form; or
- Individuals for whom drug or alcohol abuse diagnostic or treatment information is being shared. In these cases, a separate consent form (attached) should be used.

Can Other Interagency Consent Forms Be Used?

Agencies should accept the *Consent to Exchange Information* form as a legally valid form. However, they may choose to use a different release form that addresses their individual needs IF it meets the state and federal confidentiality statutory and regulatory requirements of ALL the involved agencies.

COMMONWEALTH OF VIRGINIA
UNIFORM CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CLIENT)

_____
(CLIENT'S ADDRESS) *(CLIENT'S BIRTHDATE)* *(CLIENT'S SSN - OPTIONAL)*

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information *(except drug or alcohol abuse diagnoses or treatment information)* about the client to be exchanged:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
Other Information (write in):						☐	☐	All of the Above

I want _____
_____
___
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following other agencies to be able to exchange this information:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Nursing Facilities	☐	☐	Area Agencies on Aging	☐	☐	Community Services Board
☐	☐	Home Health Agencies	☐	☐	DMHMRSAS	☐	☐	Hospices
☐	☐	Local Health Departments	☐	☐	Physicians	☐	☐	Hospitals
☐	☐	Dept. of Social Services	☐	☐	Dept. of Medical Assistance Srvcs	☐	☐	Other:
Are more agencies listed on back?	☐	☐						

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination ☐ Other:

I want this information to be shared by the following means: *(check all that apply)*
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax

I want to share additional information received after this consent is signed: ☐ Yes ☐ No

This consent is good until: ☐ My service case is closed. ☐ Other: _____

DECLARATION OF CONSENT

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all the agencies to accept a copy of this form as a valid consent to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.**

Signature(s): _____Date: _____
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: _____

(Name) *(Title)* *(Phone Number)*

Witness (*If Required)*:_____

(Signature) *(Address)* *(Phone Number)*

COMMONWEALTH OF VIRGINIA
UNIFORM CONSENT TO EXCHANGE INFORMATION

Full Printed Name of Client:_____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED: _____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

(AGENCY REPRESENTATIVES FULL NAME AND TITLE)

(AGENCY ADDRESS AND TELEPHONE NUMBER)

5-14-92; revised 4-98 for Uniform Assessment Instrument Manual

Instructions for Completing the Consent to Exchange Information Form

PURPOSE - The "Consent to Exchange Information" form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs. It also can be used to assist agencies to obtain information needed from other agencies to determine an individual's eligibility for services or benefits.

Agencies may use this form in lieu of forms that are currently used and receive the same legal protections. The only exception involves drug and alcohol patient records which are governed by federal regulations.

This form DOES NOT change existing state or federal laws or program - specific regulations under which agencies operate.

This form should be viewed as the end product of a discussion between the worker and the client or the client's authorized representative which documents the client's decision on when and what type of information can be released or obtained. This form should NOT BE USED with a client who does not comprehend the purpose and substance of the Consent Form.

WHEN PROPERLY EXECUTED, THIS IS A LEGALLY VALID DOCUMENT FOR EXCHANGING CLIENT INFORMATION. TO BE PROPERLY EXECUTED ALL STATEMENTS MUST BE COMPLETED WITH THE APPROPRIATE INFORMATION AND/OR BY CHECKING THE APPROPRIATE YES OR NO BOX.

CONSENTING PERSON OR PERSONS - Enter the full name of the person/persons authorizing the exchange of information.

NAME OF CLIENT - Enter the full name of the client about whom the information will be shared.

CLIENT'S ADDRESS, BIRTHDATE, SOCIAL SECURITY NUMBER (SSN) - Enter the client's address, date of birth, and social security number (SSN). *NOTE: Section 2.1-385 of the Code of Virginia makes it unlawful to require a client's social security number in order to obtain benefits or services unless a specific law allows the agency to require it.*

RELATIONSHIP TO Client - Check the consenting person's relationship to the client. Note: A legally valid consent requires that one of the listed relationships be present.

INFORMATION TO EXCHANGE - Check the appropriate box next to the information the client wishes to exchange among the listed agencies. If necessary, write in any other information the client wishes to exchange. *NOTE: If the client wishes to limit some of the information to be exchanged in any category, the limitations must be recorded on the back of the form. A client may want to exchange most, but not ALL, of the specific information checked "Yes" (e.g., a reference to past psychiatric hospitalization contained in psychiatric records). If the client wants some specific parts of a record to remain confidential, the referring agency MUST exclude this information when that record is shared with the other agencies).*

REFERRING AGENCY AND STAFF CONTACT PERSON - Enter the name and address of the agency which initiates the completion of the form. The staff contact person is the name of the staff person who discussed/explained the use of the form with the client and, if appropriate, assisted the client in completing the form.

SHARING AGENCIES - Check the type of agencies with which the information will be exchanged. If more space is needed, additional agencies can be listed on the back of the form. The consenting person(s) must place his or her signature or initials beside the name(s) of each agency listed on the back. The referring agency should notify the listed agencies that they are parties to the CONSENT TO EXCHANGE INFORMATION. This notification can be by telephone or written correspondence. This notification must be recorded in the client's record. If the referring agency wants to obtain information from the listed agencies, it must provide a copy of the signed consent form. The copy may be mailed or faxed.

MORE AGENCIES LISTED - Check the appropriate box if more agencies were listed on the back of the form.

PURPOSE OF EXCHANGE - Check the appropriate box(es) or enter other purposes in the designated space.

HOW THE INFORMATION IS EXCHANGED - Check all appropriate boxes.

SHARING OF NEW INFORMATION - The client can limit the exchange of information contained in the record as of the date of the consent by checking the NO box. Information not in the record after the consent is signed can be exchanged by checking the YES box.

EXPIRATION - The length of time the consent is valid should bear a relationship to the client's participation in a project, service plan or treatment plan, and should be the client's choice. The consent form may NOT be valid "forever", "indefinitely" or for extremely long periods of time. Unless the client specifies a particular date or circumstances, acceptable length of time would be "until placement" or "until my case is closed".

SIGNATURES - The consenting person(s) must sign and date the form. A copy of the signed consent form must be given to the consenting person(s). If the consenting person cannot write and/or does not speak English, he or she will put his or her mark (i.e., initials, an "X") in the signature space. The staff person explaining the form to the consenting person(s) must sign the form and enter identifying information and a telephone number. If the agency procedures require a witness to a consenting person's mark, space is provided for his or her signature. The witness must observe the consenting person sign or place a mark on the form.

REVOCATION OF CONSENT - The consent to exchange information will expire on the date or circumstances agreed to by the consenting person(s). The consenting person(s) may revoke all or part of the consent at any time prior to the expiration by notifying any of the involved agencies. This notification can be by telephone, in writing, or in person. This notification to revoke must be documented on the back of the consent form by checking the appropriate boxes and entering the applicable information.

NOTIFICATION OF REVOCATION - The agency receiving the revocation notice must notify in writing all listed agencies of the client's revocation of his or her consent, either entirely or partially. Notification must be recorded in the case record.

RENEWING OR AMENDING THE CONSENT FORM - The referring agency can renew or amend the original consent form by having the consenting person(s) sign and date beside the amendment(s) on the original form. A copy of the amended form must be given to the consenting person(s) and an amended copy must be sent to all listed agencies.

INTERAGENCY CONSENT TO RELEASE CONFIDENTIAL INFORMATION FOR ALCOHOL OR DRUG PATIENTS

I, _____, of _____
(Name of patient/client) *(Patient/client's address)*

authorize _____ to disclose to
(Custodian of information)

_____
(Name, title, and organization to whom disclosure is to be made)

the following information: _____
(Specific information to be disclosed)

for the following purpose(s): _____
(Reason for disclosure)

_____

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as described below:

_____
(Date, event, or condition upon which this consent will expire)

I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Executed this, the _____day of _____, 19_____

This consent ☐ includes ☐ does not include information placed on my records after the above date.

_____
(Signature of patient/client)

_____
(Signature of parent/guardian, where required)

_____
Signature of person authorized to sign in lieu of parent)

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is <u>NOT</u> sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Instructions for Preparing the Interagency Consent to Release Confidential Information for Alcohol or Drug Patients

PURPOSE - This form is used in lieu of the "Consent to Exchange Information" form when sending or requesting information from a substance abuse program.

A substance abuse program is an entity that receives federal funds of any type that is providing one or more of the following:

- Diagnosis
- Treatment
- Referral for Treatment of Substance Abuse

Only substance abuse programs meeting this definition are governed by federal regulations.

Substance abuse programs covered by federal regulations may release information which identifies a person as a substance abuser, as a general rule only when:

- The person has consented to the release of information by signing the special form.
- A medical emergency exists and the information is being released to medical personnel.
- The court authorizes release.

DISCLOSURE LOG: CONSENT TO EXCHANGE INFORMATION

_____

(NAME OF AGENCY AND STAFF CONTACT PERSON)

_____

(FULL PRINTED NAME OF CLIENT) *(CASE NUMBER)*

_____

(CLIENT'S ADDRESS) *(CLIENT'S BIRTH DATE)* *(CLIENT'S SSN - OPTIONAL)*

Log of Disclosure of Information:

Receiving Agency	Name, Title, Telephone Number of Individual Receiving Information	Type and Source of Information Disclosed	Reason or Purpose of Disclosure	Date Disclosed

Instructions for Preparing the Disclosure Log

PURPOSE - To ensure compliance with the requirements of the Virginia Privacy Protection Act. Each time information is disclosed by any of the lis ted agencies, staff of the disclosing agency must enter the following information in the client's record:

1. Name of the agency and the name, title, and telephone number of the individual receiving the information.
2. Type and source of the information disclosed.
3. Reason or purpose for the disclosure.
4. Date that the information was disclosed.

This requirement can be met either by using the disclosure log or by following the agency's current procedures to meet disclosure requirements.

CLIENT NAME - Enter the name, address, birthdate, and social security number (SSN) (optional) of the client about whom the information is disclosed.

LOG INFORMATION - Enter the information required in the appropriate box(es).

Appendix C

Title III Care Coordination
Care Coordination for Elderly Virginians Program
Department for the Aging
Utilization Review

Client Name: _____ Agency _____

Address: _____ Telephone: _____

DMAS: _____ SSN: _____

Care Coordinator: _____ Case Opened: _____ Case Closed: _____

Reason for Referral:

_____

_____

Required Documentation in Client Record:

Document	Y	N	Document	Y	N
Original UAI			Consent to Exchange Information Form		
Original Care Plan			Care Coordination Fee Form (CCEVP)		
Monthly Progress Notes			Purchase of Gap-Filling Services Form (CEEVP)		
Reassessments			Acceptance/Denial Notice		
Care Coordination Outcome Report			Nutritional Screening		
Federal Poverty Level			Client Bill of Rights		
Intake Instrument					

Reassessment Dates: _____

Diagnoses: _____

Comments/Findings:

Care Plan:

_____

_____

_____

_____

_____

Monthly Progress Notes:

_____

_____

_____

_____

_____

_____

List of Multiple Services:

Service	Provider	Opened	Closed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Comments:

Purchase of Gap-Filling Services Form:

Summary:

VDA staff: _____ Date: _____